years old. There are alternations in the maximum values for gender in the 0 to 20 years old band. **CONCLUSIONS:** This study reflects the need to determine an optimum number of bands; that is, to add the information in some specific intervals that allow us to carry out an efficient analysis without losing the necessary perspective in order to obtain related conclusions with the aim of the study. It proves that a previous analysis is essential to evaluate the behaviour of the cost per inhabitant of a PHCT.

PHP28

THE ORGANIZED REGISTER OF CANADIAN HEALTH INFORMATION DATABASES (ORCHID) PROJECT: A RESEARCHER INTERFACE

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OBJECTIVES: To organize and classify existing Canadian health information databases into a searchable repository that will assist in identifying and assessing Canadian data available for health outcomes and related research. **METHODS:** The identification of Canadian health information databases began with a structured search strategy involving Medline (PubMed, OVID); Internet search engines; web sites of a number of organizations, universities and government bodies; and personal communications. Canadian databases with data from the year 2000 and onwards were included. Databases were assigned to one of four basic types (Administrative, Registry, Surveillance and Survey) and further classified in a hierarchical structure using categories, sub-categories and low-level terms. The three high-level categories were Medical Condition (MC), Population Health (PH) and Health Services Utilization (HSU). Approximately 20% of the identified databases were further profiled in detail, with recording of information on an additional 20 variable fields including sample size, data collection methods and data quality. **RESULTS:** The creation of a classification structure fully characterized the breadth and scope of the 255 unique databases initially identified. By database type, the largest proportion of databases was classified as survey (34%; n = 87), followed by administrative (28%; n = 72), registry (22%; n = 56) and finally surveillance (16%; n = 40). By non-exclusive database category, most were classified as PH (n = 140), followed by HSU (n = 116) and finally MC (n = 114). Canadian health databases were found to provide information across a wide range of clinical conditions, particularly those related to high disease burden areas. In addition, they provided health utilization and determinant data. Some data gaps were recognized, such as environmental exposure data, data identifying specific subpopulations, and information needed to fully assess data quality. **CONCLUSIONS:** Classifying existing Canadian health information databases within a single, organized register is expected to provide an effective research tool in the planning of health outcomes and related research.

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PATHOLOGY RELATED DIFFERENCES IN VARIANCE OF DRUG INSURANCE COST IN HOSPITAL STAYS: FEASIBILITY OF FIXED FUNDING IN PATHOLOGIES WITH REDUCED COST VARIANCE

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OBJECTIVES: Parameters of central tendency (mean) are often estimated in budget impact assessment (BIA) with less emphasis on parameters of spread (variance); critical to fixed funding (FF) policies (e.g. envelope systems) is accuracy of the estimate and maximal precision. The complexity and diversity of the hospital pathology mix and its treatment are the main theoretical hurdles encountered. In this analysis, the variance of the drug treatment reimbursement cost was investigated on the Main Diagnostic Code (MDC) and the All Patients Refined Diagnosis Related Groups (APRDRG)-level. The aim was to select low cost variance diagnoses which would enhance precision in FF. **METHODS:** Belgian hospitals register admission data in minimum basic data sets (MBDS): we extracted anonymous data from stays of 21 peripheral Flemish hospitals (during 2002). MBDS contains ICD-9-CM codes, performed procedures, stay parameters (e.g. risk of mortality), patient characteristics (age, gender) and drug utilization data with the national insurance cost. Data were analyzed in SPSSWIN® 12.0. **RESULTS:** The database contained 368,618 unique stays. On MDC-level, the fit between mean cost and variance was merely a non-linear relationship; the MDC's cardio-vascular (CV) disease, myeloproliferation & neoplasms, infectious disease and liver disease exhibited a linear relationship with $r2 > 0.90$; in these MDC's low mean cost pathologies also allow fixed funding. On APRDRG-level, increased cost variance probably reflects increased drug utilisation variability and/or heterogenicity in drug pricing. Illustrative examples: the ratio of mean cost for cesarean (95€) to vaginal (27€) delivery is about 4 but the ratio of variances exceeds 10. In the CV area, the corresponding ratios for heart failure (269€) to angina (104€) are respectively 2.5 and 8. **CONCLUSIONS:** Reducing mean cost is important to BIA but to FF reducing cost variance is essential in order for the funding to be in line with the resources used.

PHP30

2006 DRUG PAYMENTS IN THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM: REIMBURSEMENT IMPLICATIONS

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OBJECTIVES: The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 requires the General Accounting Office (GAO) to conduct surveys in 2004 and 2005 to determine the hospital acquisition cost for specified outpatient drugs. The Centers for Medicare and Medicaid Services (CMS) will use the survey data to set hospital outpatient drug payment rates for 2006. This study explores the potential impact of poor study design on 2006 hospital outpatient prospective payment system (OPPS) drug payments. **METHODS:** Various methods of recording acquisition cost were collected from hospital systems and categorized. Past CMS and GAO discussions of acquisition cost were identified and accumulated in an indexed database. Findings from the hospital sources and the governmental sources were compared and underlying assumptions examined with a view toward predicting the GAO approach to determining hospital drug acquisition cost. **RESULTS:** The hospital survey revealed significant variation in how acquisition cost is defined and recorded in hospital pharmacies. The most common method reported was a percentage of average wholesale price (AWP). The next most common method reported was actual acquisition cost at a certain point in time, updated quarterly. Constantly updated acquisition cost was rare, due to the required information technology. When entries in the indexed database of CMS and GAO discussions of acquisition cost were compared to the hospital